

DISCOVERY & INNOVATION UNIT PROCEDURE

RESEARCH MISCONDUCT PROCEDURE

Staff this document applies to:

- All Austin Health staff including honoraries
- All visitors involved in research associated with or supported by Austin Health, including fellows, scholars and students

Related Austin Health policies, procedures or guidelines:

- [Code of Conduct Policy](#)
- [Conflict of Interest Policy](#)
- [Consent Policy](#)
- [Delegations of Authority Policy](#)
- [Financial Management Policy](#)
- [Fraud, Corruption Control & Other Losses Policy](#)
- [Gifts, Benefits & Hospitality Policy](#)
- [Patient Safety & Clinical Excellence Framework](#)
- [Public Interest Disclosure Policy](#)
- [Public Interest Disclosure Procedure Research Policy](#)
- [Research Authorship and Outputs Procedure](#)
- [Research Data Management Procedure](#)

Key points:

This Procedure covers the following topics:

- **Part A:** When to apply this procedure
- **Part B:** Institutional responsibilities
- **Part C:** Institutional roles
- **Part D:** Responsibilities of individuals
- **Part E:** Considering and making a formal allegation
- **Part F:** Protected Disclosure Act
- **Part G:** Formal complaint
- **Part H:** Response by designation officer to a formal complaint
- **Part I:** Conducting a preliminary assessment
- **Part J:** Actions following a preliminary assessment

- **Part K:** Decisions following preliminary assessment
- **Part L:** Preparing for the investigation
- **Part M:** Conduction of the investigation
- **Part N:** Outcome of the investigation
- **Part O:** Requesting review of the investigation outcome
- **Part Q:** Collaborative research across multiple institutions
- **Part R:** Allegations made against honorary staff
- **Part S:** Allegations made against a person who has left Austin Health
- **Part T:** Governance of Roles and Responsibilities

Scope

This Procedure states the requirements for the attribution and management of research authorship in line with criteria set out in the [Australian Code for the Responsible Conduct of Research \(2018\) \(the Code\)](#) and supporting [Guide to managing and investigating potential breaches of the Australian Code for the Responsible Conduct of Research, 2018 \(or as amended\)](#).

This Procedure covers research which can reasonably be regarded as the responsibility of Austin Health.

Professional misconduct that falls outside the description defined by the Code should be handled under institutional processes for dealing with other forms of misconduct, for example harassment or bullying.

Purpose

The purpose of this Procedure is to provide a clear outline of reporting, assessment, investigative, management and resolution requirements for complaints and allegations of breaches of research integrity.

1. The Australian Code for the Responsible Conduct of Research (version in force as varied from time to time) (the Code) articulates the broad principles that characterise an honest, ethical and conscientious research culture. The Code sets out principles and responsibilities that both researchers and institutions are expected to follow when conducting research to ensure successful research.
2. A failure to meet the principles and responsibilities set out in the Code is a breach of the Code. A breach of the Code occurs on a spectrum from minor breaches to those that are more serious. A serious breach of the Code that is carried out with intent or recklessness or negligence is particularly egregious and is referred to as research misconduct for the purpose of this procedure.
3. This Procedure outlines the process for how Austin Health will respond to complaints and allegations of breaches of the Code as outlined by the [Guide to Managing and Investigating Potential Breaches of the Code](#) version in force as varied from time to time (the Investigation Guide) which should be read in conjunction with the Code.
4. The responsible conduct of research includes management of research data and primary materials, supervision of students and research trainees, scientific authorship and dissemination of research findings, peer review, management of conflicts of interest, management of collaborative research, adherence to ethical principles applied to human research, and minimisation of impacts on animals.

Part A – When to apply this Procedure

This Procedure will be applied when there is a possible breach of the Australian Code of Conduct for Responsible Research. A breach is defined as a failure to meet the principles and responsibilities of the Code and may refer to a single breach or multiple breaches. Examples of breaches of the Code include, but are not limited to, the following:

- a. **Not meeting required research standards**
 - i. Conducting research without ethics approval as required by the [National Statement on Ethical Conduct in Human Research](#) (version in force as varied from time to time), [the Australian Code for the Care and Use of Animals for Scientific Purposes](#) (version in force as varied from time to time), the Gene Technology [Act](#) and [Regulations](#), the Australian Sanctions and the relevant Biosecurity and Export Control regulations.

- ii. Failing to conduct research as approved by an appropriate ethics review body.
- iii. Conducting research without the requisite approvals, permits or licences.
- iv. Misuse of research funds.
- v. Concealment or facilitation of breaches (or potential breaches) of the Code by others such as not reporting potential breaches and/or facilitation of the above practices which breach the Code.

b. Fabrication, falsification, misrepresentation

- i. Fabrication of research data or source material
- ii. Falsification of research data or source material
- iii. Misrepresentation of research data or source material
- iv. Falsification and/or misrepresentation to obtain funding.

c. Plagiarism

- i. Plagiarism of another's work, including theories, concepts, research data and source material.
- ii. Duplicating a publication (also known as redundant or multiple publication, or self-plagiarism) without acknowledgment of the source.

d. Research data management

- i. Failure to appropriately maintain research records
- ii. Inappropriate destruction of research records, research data and/or source material
- iii. Inappropriate disclosure of, or access to, research records, research data and/or source material.

e. Supervision

- i. Failure to provide adequate guidance or mentorship on responsible research conduct to researchers, research trainees or research students under their supervision.

f. Authorship

- i. Failure to acknowledge the contributions of others fairly.
- ii. Misleading ascription of authorship including failing to offer authorship to those who qualify or awarding authorship to those who do not meet the requirements.

g. Conflicts of interest

- i. Failure to disclose and manage conflicts of interest.

h. Peer review

- i. Failure to conduct peer review responsibly.

5. **Breaches range in severity.** Major breaches will require an Investigation. Minor breaches can be addressed at the Preliminary Assessment stage (as outlined in **Parts L and M**). The severity of a breach is determined on a case-by-case basis. Consideration of the type of behaviour may be used to infer whether the breach is intentional or reckless or negligent and represent research misconduct. Fabrication and falsification are types of breaches that are commonly recognised as being undertaken intentionally or recklessly and are examples of research misconduct. Repeated or persistent breaches, especially after repeated corrective actions from preliminary assessments or as requested by the approving Ethics Committee and/or other delegated authority will constitute a serious breach, which will trigger consideration of research misconduct.
6. Honest differences in judgement and unintentional errors do not usually constitute research breaches of the Code unless they result from behaviour that is reckless or negligent.
7. Allegations of a breach may overlap with allegations of fraud that relates to funding (for example, where it is alleged that falsified data was used in an NHMRC funded project).

8. Factors that will be considered in determining whether a Breach represents a minor or major Breach include:
 - a. the extent to which the principles and responsibilities outlined in the Code or relevant law, regulation, disciplinary standard, ethics, guideline, contractual agreement or policy have been breached
 - b. the extent to which research participants, the wider community, animals and the environment are or may have been affected by the potential breach
 - c. the extent to which the Breach affects the trustworthiness of research
 - d. whether the conduct represents a significant departure from accepted standards within the research and scholarly community for proposing, conducting or reporting research.
9. Consideration will also be given to any mitigating or extenuating circumstances that may have contributed to the Breach, including:
 - a. systematic failures, such as where the Institution has not provided appropriate resources or facilities to researchers
 - b. the level of experience of the researcher
 - c. whether there is a pattern of breaches by the researcher
 - d. whether the behaviour was accidental or intentional.
10. Where an allegation relates to a student, it must be reported as follows:
 - a. if an allegation concerns a student in the research component of any higher degree, including higher degrees by research, and higher degrees examined by a combination of coursework and research, the matter should be referred to the institution in which the student is enrolled in their degree.
 - b. if deemed appropriate, a preliminary assessment conducted under this procedure can count as a preliminary assessment when a matter is referred to another institution.
 - c. all Responsible Officers will act together in good faith to resolve the issues in a clear and transparent way when investigations are conducted under this Procedure and the policy and/or procedures of another institution.
 - d. an allegation concerning a staff member who is also enrolled in a research component of a higher degree - the investigation will firstly consider the individual as staff if the allegation relates to work they are doing as a Austin Health employee and handle the allegation according to this Procedure. Issues impacting the candidature of the staff member will be dealt with according to the provisions of their host institution they are enrolled with.

Part B – Institutional responsibilities

11. The Institution has the responsibility to facilitate the prevention and detection of potential breaches of the Code. The Institution must ensure that the process for managing and investigating concerns or complaints about potential breaches of the Code follows the principles of procedural fairness (also referred to as natural justice) and is:
 - a. **Proportional:** Investigations and subsequent actions need to be proportional to the extent of the potential breach of the Code.
 - b. **Fair:** The respondents and, where appropriate, complainants and others who may be adversely affected by any investigation must be treated fairly and in accordance with the current and relevant Austin Health Collective Agreement.
 - c. **Impartial:** Investigators and decision-makers are to be impartial and declare any interests that do, may, or may be perceived to jeopardise their impartiality. These interests are to be appropriately managed.
 - d. **Timely:** Investigations into potential breaches should be conducted in a timely manner to avoid undue delays and to mitigate the impact on those involved.
 - e. **Transparent:** Information about institutional processes should be readily available and/or provided to respondents, complainants, all employees and students engaged in research. Institutions need to ensure accurate records are maintained for all parts of the process, with records held centrally and in accordance with the relevant legislation.

- f. **Confidential:** Information will be treated as confidential and not disclosed unless required.
12. Per the [Guide to Managing and Investigating Potential Breaches of the Australian Code for the Responsible Conduct of Research](#), if a complainant chooses not to proceed with a complaint, the Institution still has an obligation to assess the nature of the complaint and determine whether to proceed to a preliminary assessment. This implies that all members of the Institution, including Research Integrity Advisors have a responsibility to report instances of major breaches that represents research misconduct.
13. Allegations of research integrity breach must be investigated whenever they are brought to the attention of the Designated Officer and/or Austin Health Executive or their delegate.

Part C – Institutional roles

14. **Responsible Executive Officer**
- a. The Chief Executive Officer is the Responsible Executive Officer who has the final responsibility for receiving reports of the outcomes of processes of assessment or investigation of potential or found breaches of the Code and deciding on the course of action to be taken.
15. **The Designated Officer**
- a. The Clinical Director of Research has been appointed by the Chief Executive Officer as the Designated Officer to whom all allegations of major breach must be reported.
- b. The Clinical Director of Research may delegate the Designated Officer role in specific cases as appropriate to the circumstances and the seriousness of the breach of the Code.
16. **Discovery & Innovation Unit** has the responsibility for the management of research integrity. All concerns, complaints or allegations should be initially directed to the Operations Director, Discovery & Innovation Unit.
17. **Assessment Officer**
- a. The Designated Officer will assign a suitably qualified Assessment Officer.
- b. The Operations Director, Discovery & Innovation Unit will assist the Designated Officer to assign senior staff within the Institution to the Assessment Officer role. The Operations Director, Discovery & Innovation Unit (or their delegate) can be assigned the role of Assessment Officer.
- c. The Assessment Officer:
- conducts a preliminary assessment overseen by the Designated Officer
 - consults with the Designated Officer, others in the institution and external experts where necessary
 - liaises with the respondent and other relevant parties as appropriate
 - secures evidence
 - manages records
 - provides a report to Designated Officer.
18. **Research Integrity Advisor**
- a. A person (or persons) appointed by the Clinical Director of Research or their delegate as an independent advisor. A Research Integrity Advisor promotes the responsible conduct of research and provides informal advice to staff and students about how to make a complaint regarding concerns about a research conduct issue.
- b. Explains the options open to a person considering, making, or having made a formal allegation of research misconduct.
- c. Does not become involved in investigating or assessing the merits of any allegation of research misconduct.
- d. Does not advise on matters where they have a potential, perceived or actual conflict of interest.
- e. Does not contact the person who is the subject of an allegation.
- f. Does not conduct investigation or assessment of the allegation, including contacting the person who is the subject of that complaint or being involved in any subsequent investigation other than as witness or to provide testimony.

19. Contact details of the Institution's Research Integrity Advisors will be maintained on the Austin Health Discovery & Innovation Unit website.

Part D – Responsibilities of individuals

20. Each person to whom this procedure applies has a responsibility to:
- apply the principles of responsible research conduct in all aspects of their research
 - bring instances of questionable research conduct to the attention of a Research Integrity Advisor, Chief Executive Officer, Clinical Director of Research or Operations Director, Discovery & Innovation Unit
 - where a complainant chooses not to proceed with a complaint, the Institution still has an obligation to assess the nature of the complaint and whether to proceed to a preliminary assessment
 - cooperate with the Designated Officer or the person they appoint as Assessment Officer in accordance with the NHMRC Investigation Guide to conduct a preliminary assessment of a complaint about research and in the review of any alleged research misconduct
 - contribute any evidence that may be relevant to an allegation of breach of the Code to the Designated Officer or delegate or a person they appoint as Assessment Officer.

Part E – Considering and making a formal allegation

21. Prior to submitting a formal complaint or allegation, a person may elect to attempt resolution via informal methods at the local level. When doing so, they must ensure they follow all relevant Institutional policies and procedures.
22. Any Austin Health employee who becomes aware of informal or local complaints and their resolution must advise the Operations Director, Discovery & Innovation Unit. The Operations Director, Discovery & Innovation Unit will then report the specifics of the informal allegations to the Designated Officer.
23. A person who has a concern or complaint about a potential research breach that may have occurred or is occurring is encouraged to approach a Research Integrity Advisor, Operations Director, Discovery & Innovation Unit or Clinical Director of Research for assistance with considering options. If the person wishes to make an allegation, they must do so with the Operations Director, Discovery & Innovation Unit who will then refer the matter to the Designated Officer.
24. Outcomes of the discussion between the any representative of the Institution (as outlined in Part C of this Procedure) and the complainant may include:
- not proceeding if the complaint is clearly not related to a breach of the Code
 - proceeding under other institutional processes
 - making a complaint about a potential breach of the Code in writing to the Designated Officer.

Part F – Protected Disclosure Act

25. The [Public Interest Disclosures Act 2012](#) (Vic) is available as an alternative complaint procedure as per the [Public Interest Disclosure Procedure](#). However, the person making an allegation should be aware that not all instances of a breach of the Code will fall within the scope of the Act.

Persons who would like to make a complaint under the Act but are unsure about how to do this can contact the Health Complaints Commissioner.

Part G – Formal complaints

26. Complainants may elect to remain anonymous and/or complaints may be lodged by third parties.
27. The Complainant may seek advice from any designated officer listed in Part C of this procedure to construct a complaint that is complete and as thorough as possible. It is not the sole responsibility of the Complainant to provide all the necessary material to reach a conclusion, nor to identify the parts of the Code or other relevant policy, law, regulation or guideline that may have been breached.
28. If a person wishes to make a formal allegation of research misconduct, the allegation must be in writing to the Designated Officer. The formal allegation must:
- clearly identify each instance of breach of the Code, indicating the place or places and date or dates on which the conduct in question is alleged to have occurred;

- b. state the identity of the person alleged to have engaged in the relevant research integrity breach and the policy, procedure or practice, which is the subject of the allegation; and
- c. identify and attach (in as much detail as possible) any supporting evidence to enable a preliminary assessment.

Part H – Response by Designated Officer to a formal complaint

29. The Designated Officer is responsible to determine whether the complaint relates to a potential breach of the Code and, how to proceed. On receipt of a formal allegation of a research breach or if the Designated Officer is made aware of an allegation which contains the elements specified in Part G of this Procedure, the Designated Officer will:
 - a. authorise a preliminary assessment to gather and evaluate facts and information, and assess whether the complaint, as evidenced, would constitute a breach of the Code
 - b. determine if the research implicated in the allegation is the reasonable responsibility of the Institution. If the Designated Officer comes to the view that the allegation refers to research that is the responsibility of another institution, the Designated Officer will refer the allegation to the other institution
 - c. consider whether any additional or alternative actions should be taken, such as referring allegations not related to research misconduct to other institutional processes
 - d. determine whether the allegation requires immediate suspension of any implicated or affected research project to ensure that all potential harm to humans, animals or the environment is minimised or avoided
 - e. have authority to secure all relevant documents and evidence so that they are available if it is decided that the allegation is to be investigated.

Part I – Conducting a preliminary assessment

30. If the Designated Officer requests that a preliminary assessment is to be undertaken, the Designated Officer will assign a suitable Assessment Officer.
31. The Assessment Officer is responsible for the conduct of the preliminary assessment, ensures timeliness and consults with the Designated Officer, as required. The Assessment Officer will ensure records of the Preliminary Assessment are prepared and securely retained after the conclusion of the Preliminary Assessment for an appropriate time period; and that appropriate processes are followed per checklists outlined in the [Guide to managing and investigating potential breaches of the Australia Code for the Responsible Conduct of Research](#).
32. **The Assessment Officer will undertake the following steps:**
 - a. formulate and record a framework for the preliminary assessment, clarifying its objectives and setting limits on its scope and determine the standard of proof to be applied
 - b. take into account any requirements of relevant legislation, the Code of Conduct and the Institution's guidelines, policies, procedures and workplace agreements
 - c. draw on expertise that may be required from other sources, such as researchers from the same or aligned disciplines, especially where the complaint relates to specific disciplinary practice (for example, authorship)
 - d. identify, collect, catalogue and secure facts and obtain all relevant documents, such as files, memos, letters or emails and secure all relevant evidence
 - e. consider whether specific and/or independent advice about the collection and storage of material evidence, facts or information is required
 - f. take all appropriate steps required for determining the validity or veracity of any of the matters raised by the allegation or about the person or persons who are the subject of an allegation of research misconduct
 - g. keep the assessment and any information from the assessment confidential to avoid compromising the preliminary assessment and will not share information unless there are compelling circumstances or required by appropriate Institutional Officers
 - h. if applicable, interview or obtain evidence from all relevant witnesses and recording the substance of the evidence provided, including written signed statements from key witnesses
 - i. ensure that if a person who is the subject of an allegation is interviewed, that person can bring a support person to the interview, as defined in the workplace agreement

- j. ensure that, as required, arrangements in the local workplace are fair to all parties until an allegation is resolved
- k. endeavour to complete the preliminary assessment within 60 working days from the date of the complaint or allegation
- l. seek assistance from any person as may be deemed necessary and appropriate in order to conduct the preliminary assessment
- m. write a report on the findings of the Preliminary Assessment and make any recommendations to the Designated Officer, noting that the findings and relevant recommendations in any report may, if considered appropriate and only after the approval of the Designated Officer, be provided to the person who is the subject of an allegation of research misconduct and to the person making the allegation
- n. ensure that the records created and retained would enable any person authorised to review the records to follow the procedures adopted by the investigator(s).

33. The Assessment Officer should consider:

- a. consultation with others in the institution
- b. the involvement of those in supervisory roles in the potential breach
- c. the need to involve other institutions in the matter.

34. For the purposes of the preliminary assessment the Assessment Officer(s) may also:

- a. seek advice on any technical matters from an appropriate person either within or outside the Institution, provided that the person has no conflict of interest or bias
- b. recommend that legal advice be sought, as appropriate to the allegation
- c. recommend if any of the allegations not related to research should be referred to another department or authority.

Part J – Actions following a preliminary assessment

35. On completion of the preliminary assessment, the Assessment Officer provides written advice to the Designated Officer. This should include:
- a. a summary of the process that was undertaken
 - b. an inventory of the facts and information that was gathered and analysed
 - c. an evaluation of facts and information about how the potential breach relates to the principles and responsibilities of the Code and/or institutional processes; and
 - d. recommendations for further action.
36. The Designated Officer must advise the Chief Executive Officer, based on the facts and information presented, whether the matter should be:
- a. dismissed
 - b. referred to other institutional processes
 - c. resolved locally with or without corrective actions and instruct the relevant directorate how to act on the allegation; or
 - d. refer the matter for Investigation.
37. Where a preliminary assessment does not support a referral for investigation, the following actions should be considered:
- a. if the complaint has no basis in fact (for example, due to a misunderstanding or because the complaint is frivolous or vexatious), then efforts, if required, must be made to restore the reputation of any affected parties.
 - b. if a complaint is considered to have been made in bad faith or is vexatious, efforts to address this with the complainant should be taken under appropriate institutional processes and addressing any systemic issues that have been identified.

38. An admission by the respondent of a breach of the Code should not be an end point. It may still be necessary to investigate and identify appropriate corrective actions, any other parties that may be complicit or any other necessary steps.
39. Where a respondent leaves the institution following a complaint, the institution has a continuing obligation to address the complaint.
40. The institution should provide the outcomes, if appropriate, to the respondent and complainant at the conclusion of a preliminary assessment in a timely manner.

Part K - Decisions following preliminary assessment

41. Upon receipt of the recommendations/advice of the Designated Officer, the Chief Executive Officer may:
 - a. dismiss any allegation of research misconduct that has been the subject of the Preliminary Assessment if they conclude the allegation is:
 - i. trivial
 - ii. frivolous, vexatious or not made in good faith
 - iii. ill founded
 - iv. such as not to require the taking of any action adverse to the person against whom the allegation has been made.
 - b. determine that the allegation is unrelated to research misconduct and deal with the allegation under relevant clauses of Institution's Collective Agreement
 - c. determine that a less serious breach of the Code has occurred and if the breach is:
 - i. not disputed, then refer the matter back to the department level with instructions as to how it should be handled under the relevant Collective Agreement and advise the staff member as to how the breach must be remedied and what steps should be taken to prevent recurrence
 - ii. disputed, then deal with any allegation in accordance with relevant Collective Agreement.
 - d. determine that a more serious breach of the Code (research misconduct) has occurred and:
 - i. if the breach is not disputed by the person or persons alleged to have engaged therein, take appropriate action in accordance with relevant Collective Agreement. However, an admission by the Respondent should not be an endpoint. It may still be necessary to investigate and identify appropriate corrective actions or other necessary steps; or
 - ii. if the breach is disputed deal with any allegation in accordance with the relevant Collective Agreement and an investigation may be required.
 - e. determines whether any implicated or affected research project requires continued suspension or termination to ensure that any harm to humans, animals or the environment is reduced or avoided.

Part L- Preparing for the investigation

42. Following preliminary assessment, the respondent will be given reasonable opportunity to be heard and/or be given not less than ten (10) working days to make written submissions, in relation to the allegations.
43. If an allegation of research misconduct is to be pursued, the Chief Executive Officer will authorise an investigation as per the Collective Agreement and an investigation panel will be constituted as per the requirements of the [Investigation Guide](#) in agreement with the Collective Agreement.
44. The purpose of the investigation is to make findings of facts to allow the Chief Executive Officer to assess whether a major breach of the Code has occurred, the extent of the breach and the recommended actions. This is done by examining the facts and information from the preliminary assessment and gathering and examining further relevant evidence if required.

45. **The Designated Officer, with assistance from the Assessment Officer, will:**
 - a. prepare a clear statement of the allegation
 - b. develop the terms of reference for the Investigation panel (the Panel); a sample checklist for the Panel terms of reference is at Appendix 2 of the [Investigation Guide](#)
 - c. nominate the panel and chair
 - d. notify all those required to attend the investigation
 - e. provide sufficient detail to the respondent about the allegation to enable an informed response.
46. A range of factors should be considered when determining the size and composition of the panel, including the potential consequences for those involved, the seniority of those involved and the need to maintain public confidence in research. These factors will affect the level of independence that is required of members from both the Institution, and the respondent and complainant. There will be occasions where the Chief Executive Officer may decide that some or all members of the Panel should be external to the Institution.
47. Once a panel is established, it should be provided with all relevant information and documentation.
48. Panel members will be provided with written appointments, be required to sign a confidentially agreement, and, in the case of external members, provided assurance and conditions of indemnity.
49. The members of the panel must agree to:
 - a. work within the Institution's processes
 - b. follow the procedure established for the Panel
 - c. work within the terms of reference for the Panel
 - d. respect any undertakings of confidentiality
 - e. declare any conflict of interest
 - f. adhere to the principles of procedural fairness
 - g. complete the Investigation in a timely manner
 - h. provide a written report.
50. The Operations Director, Discovery & Innovation Unit will provide appropriate resources to the Panel, including secretariat support if required. The Assessment Officer will maintain the record of evidence.

Part M – Conduct of the investigation

51. The conduct of the Investigation will follow the investigation requirements outlined in the NHMRC [Investigation Guide](#).
52. As part of the investigation, the respondent should be provided with an opportunity to respond to the allegation and relevant evidence, and to provide additional evidence upon which the panel may rely. If the respondent chooses not to respond or fails to appear before the panel where and when requested, the investigation continues in their absence. The complainant may also be given the opportunity to see relevant evidence used in the investigation (e.g., if they are directly affected by the investigation).
53. The panel should be provided with all available information that will inform the investigation, which includes:
 - a. the initial complaint
 - b. all relevant information assembled by the Assessment Officer
 - c. records of the conduct of the preliminary assessment
 - d. the report of the preliminary assessment
 - e. records of any communications on the matter involving the Designated Officer, the Assessment Officer, the complainant and/or the respondent.

54. With the support of the Operations Director, Discovery & Innovation Unit, the Panel will develop an investigation plan (described in Appendix 3 of the [Investigation Guide](#)).
55. All those asked to give evidence are to be provided with relevant, and if necessary, de-identified information including:
 - a. the schedule of meetings and/or hearings they are asked to attend
 - b. the relevant parts of the terms of reference for the investigation, if appropriate
 - c. advice as to how the Panel intends to conduct interviews
 - d. whether they may be accompanied by a support person
 - e. advice about whether the interviews will be recorded
 - f. whether an opportunity will be provided to comment on matters raised in the interview
 - g. disclosing interests
 - h. the confidentiality requirements
 - i. the Panel's procedures.
56. The panel is to determine whether, having regard to evidence and on the balance of probabilities, the respondent has breached the Code.
57. The panel is encouraged to come to a consensus. If there are dissenting view(s), there should be opportunity for the panel member to provide this view for inclusion in the draft and final report. Because the dissenting view forms part of the draft report, it must be provided to the respondent and, in some circumstances the complainant, if they will be affected by the outcome.
58. If the panel finds during the investigation that the scope and/or the terms of reference are too limiting, it should refer the matter to the Designated Officer. The Designated Officer may decide to amend the scope of the investigation and the terms of reference. Should this occur, the respondent and relevant others are to be advised, and the respondent given the opportunity, to respond to any new material arising from the increased scope.
59. On completion of the investigation, the panel prepares a draft written report of the investigation. Given that the report will be relied on by the Chief Executive Officer to decide about whether a major breach of the Code has occurred, it is essential that the report is detailed, accurate and cogent, and fully addresses the terms of reference. The Operations Director, Discovery & Innovation Unit will provide secretariat support to assist in the preparation of the draft report.
60. The draft report should contain findings of fact and any recommendations (see Appendix 4 of the [Investigation Guide](#) for a sample checklist for the report of the investigation findings).

Part N – Outcome of investigation

61. An Investigation should seek to be completed within six months from the date of a decision to complete an investigation.
62. Where the Chief Executive Officer accepts that a major breach of the Code has been found, the Clinical Director of Research decides the institution's response, taking into account the extent of the breach and whether other institutions should be advised.
63. In the case of joint and/or honorary appointments of the respondent, Austin Health will follow established internal processes relating to these appointments and may consider seeking legal or other expert advice in relation to the management of these appointments with other institutions.
64. Following the outcome of an Investigation, a copy of the decision of the Chief Executive Officer must be promptly provided in confidence to the person against whom the allegation has been made and to the person making the allegation.
65. The Chief Executive Officer will inform all relevant parties of the Investigation findings and the actions taken by the Institution. Relevant parties may include affected staff, research collaborators including those at other institutions, all funding organisations, journal editors, and professional registration bodies. The public record, including publications, will need to be corrected if research misconduct has affected the research findings and their dissemination.
66. The findings of an independent, external Investigation may be made available to the public. Public statements may be made as appropriate.

67. Appropriate actions must also be taken when the allegations of misconduct are demonstrated to be unfounded. The following will need to be considered:
 - a. if the allegation has no basis in fact, then efforts must be taken to restore the reputations of those alleged to have engaged in improper conduct.
 - b. if an allegation is considered to have been frivolous or vexatious, action to address this with the complainant should be taken under appropriate institutional processes, including consideration of the way such communication is carried out. Support for both the respondent and complainant must be considered.

Part O – Requesting review of the investigation outcome

68. A person against whom action has been taken by the Chief Executive Officer pursuant to this procedure or the person who has made the allegation may have a right to make a request for further review by the Australian Research Integrity Committee.
69. The complainant and respondent have 10 working days from the date on which they are informed of the outcome of an Investigation, or 10 working days from the date on which they become aware of new and relevant information, to lodge a request to reopen the Investigation or lodge an appeal in writing to the Chief Executive Officer.
70. Appealing or reopening an Investigation may be appropriate where new and relevant information not available to the Panel comes to light, to correct errors or injustice, or where there is a perceived denial of Procedural Fairness. However, an Investigative process will not be reopened to simply try to achieve a different outcome. For example, a conflict of interest could invalidate a process and require that it be redone without conflict. However, this would not be the case if the conflict of interest was considered, addressed and managed appropriately.
71. In the event that the Chief Executive Officer determines that there are grounds for reopening or accepting an appeal of the outcome of an Investigation, the matter will be referred to a higher authority, such as an independent adjudicator or Panel comprised of a larger number of members or having greater experience / expertise, more rigorous processes, or greater resources.
72. In accordance with the principles of procedural fairness, respondents will be given as much warning of the decision to reopen or accept an appeal of the outcome.
73. The Australian Research Integrity Committee (ARIC) provides a review system of institutional processes responding to Allegations of Breaches of the Code for institutions that are in receipt of funding from the NHMRC or the ARC. More information about ARIC and how to request a review from ARIC is available on the NHMRC website.
74. Given that confirmed breaches can lead to serious penalties, Respondents who are the subject of such findings may also have an entitlement to appeal to the courts.

Part P – Reporting to relevant institutions and authorities

75. **Reporting outcomes of major breach of the Code requires:**
 - a. Written documentation of the preliminary assessment, investigations, outcome and justification and reports on actions provided to the Operations Director, Discovery & Innovation Unit to be included in the breach register.
 - b. The Chief Executive Officer or nominee will inform all relevant parties of the decision and outcome. Relevant parties may include but are not limited to affected staff, research collaborators including those at other institutions, all funding organisations, journal editors, ethics committees and professional registration bodies.
 - c. The Operations Director, Discovery & Innovation Unit will submit quarterly reports to the Research Steering Committee on the occurrence and nature of allegations and any actions to address the underlying causes and will regularly report to the Austin Health Board Audit & Risk Committee.
76. Suspected breaches of the Code must be reported to the relevant institution and/or authority as per the requirement of the Code of Conduct and the relevant legislations and guidelines:
 - a. Under the *Australian Privacy Act 1988* (Cth) the Institution is required to notify the Office of the Australian Information Commissioner (OAIC) when a data breach is likely to result in serious harm to individuals whose personal information is involved in the breach.

- b. The Institution must inform the Australian Research Council (ARC) on the outcomes of a preliminary assessment of a suspected research integrity breach related to ARC funded research as per the ARC Research Integrity Policy.
- c. Allegation or finding of a Breach of the Code should be reported to the NHMRC according to the NHMRC Research Integrity and Misconduct Policy (2019) if the Institution and/or administering body determines such disclosure is necessary to fulfil obligations under the NHMRC Funding Agreement, the Code or other funding/cooperative agreement.

Part Q – Collaborative research across multiple institutions

77. Consideration should be given to how potential breaches of the Code will be investigated at the outset for collaborative research projects that reach across multiple institutions and jurisdictions.
78. The Institution will consider how preliminary assessments and investigations into potential breaches of the Code are to be conducted for multi-institutional collaborations on a case-by-case basis, taking into consideration issues such as the lead institution, where the complaint was lodged, where the events occurred and contractual arrangements.
79. Institutions should cooperate if there is a potential breach of the Code to ensure that only one investigation is conducted. There should be clear communication between all parties throughout the investigation.
80. Special consideration needs to be given to international collaborations since research practices and guidelines about the conduct of investigations differ between countries.

Part R – Allegations made against honorary staff

81. If the subject of a Preliminary Assessment by the Designated Officer is an honorary of the Institution, and the Designated Officer makes a finding that the alleged conduct occurred and such person concedes the research misconduct alleged, the Chief Executive Officer will take appropriate action which may include (but is not limited to):
 - i. counselling the person
 - ii. advising them as to how the research misconduct must be remedied
 - iii. how they can take steps to prevent recurrence
 - iv. informing their current employer of the outcome.
82. If a person disputes the research misconduct alleged, the Chief Executive Officer shall initiate an investigation consistent with the Investigation Guide (note that such an investigation does not need to be convened in accordance with or comply with the obligations set out in the Collective Agreement).
83. The finding(s) and/or recommendation(s) of the investigation established by the Designated Officer must be submitted to the Chief Executive Officer who shall determine the means of addressing the matter as appropriate to the circumstances.
84. A person against whom research misconduct has been determined has 30 working days to provide a request for review of the decision.

Part S – Allegations made against a person who has left Austin Health

In circumstances in which the person(s) against whom allegations of research misconduct were made has left the Institution, a Preliminary Assessment to establish the facts may be pursued by the Designated Officer. Any distortions of the research record may need to be corrected, irrespective of whether the person involved remains at the Institution.

Part T – Governance of Roles and Responsibilities

Role/Decision/Action	Responsibility	Conditions and limitations
Receives concerns regarding potential breaches of the Code and refers them to preliminary assessment. Oversees Austin Health's processes for responding to potential breaches of the Code.	Operations Director, Discovery & Innovation Unit	Will recuse themselves and delegate responsibility in cases where there could be a perceived or actual conflict of interest in their involvement.
Prepares materials for preliminary assessment of a complaint about research and supports the investigation panel.	Designated Assessment Officer	Will recuse themselves from cases where there could be a perceived or actual conflict of interest in their involvement.
Refers a potential breach of the Code for formal Investigation.	Austin Health CEO	Will recuse themselves and delegate responsibility in cases where there could be a perceived or actual conflict of interest in their involvement.
Receives reports on formal Investigations into a potential breach of the Code and decides on the course of action to be taken.	Clinical Director of Research	Will recuse themselves and delegate responsibility in cases where there could be a perceived or actual conflict of interest in their involvement.
On request conducts a procedural review of a formal investigation of a breach of the Code on the grounds of procedural fairness.	Designated Assessment Officer	A senior officer of the institution, not fulfilling any of the roles described above. Or an independent reviewer.
Promotes the responsible conduct of research at Austin Health and provides advice to those with concerns or complaints about potential breaches of the Code.	Research Integrity Advisors (RIA)	Appointment by nomination Clinical Director of Research
Provide legal advice to Austin Health and staff named in this procedure.	General Counsel	Engagement of General Counsel to be managed via Discovery & Innovation Unit.

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Legislation/references/supporting documents:

- [NHMRC Australian Code for the Responsible Conduct of Research \(2018\)](#)
- [NHMRC Authorship Guide](#)
- [NHMRC Publication and dissemination of research guide](#)
- [NHMRC Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders 2018:](#)
- [AIATSIS Guidelines for Ethical Research in Australian Indigenous Studies 2012](#)

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